Attachment 12

Office of Administration
Commissioner's Office

REIMBURSEMENT REQUEST FOR OTHER SERVICES

Program: **Alternatives to Abortion**

Contractor: Alliance for Life

Subcontractor: Alpha House Pregnancy Resource Center

Please enter below the information for each item/service to be purchased. List the date of purchase, item to be purchased, cost for the item, and the justification. Items must be approved **before** purchased/p[redacted]

Client Name [redacted] *Date Enrolled* 1/25/2017

Proposed Purchase Date	Item	Total Cost (include formal estimate from provider of services)	Justification, include other sources of funding that have been attempted
6/27/2017	Birth Certificate for baby and herself	Baby: $15.00 Client: $30.00 Total: $45.00	Client does not have copy of her birth certificate or her baby's birth certificate. There are no places in the area to refer the client to for financial assistance for birth certificates. Client needs birth certificates for her personal records.
Amt to be reimbursed			

The following items and services are not eligible for reimbursement: taxes, travel expenses, shipping charges, insurance, interest, penalties, termination payments, attorney fees, and liquidated damages. Please subtract these charges from your total reimbursement request prior to submission.

Authorized person requesting purchase: Rebecca C. Volk

Alliance for Life Program Manager: Carrie Kelcher

Purchase is Approved ___ Denied ___ A2A Signature _____ Date _____

Reason for denying purchase: _____

Polk County Health Center
"Protecting Healthy Communities"
www.polkcountyhealth.net
PO Box 124
1317 W Broadway St
Bolivar, MO 65613
Phone: (417) 326-7250
Fax: (417) 326-2766

$16.00 [redacted]

Beginning [redacted] identification when requesting certified copies of a vital record at the state health department. Mail-in requests must be notarized by an acceptable notary public.
Missouri law requires a non-refundable search fee for each five-year search of the files. If eligibility requirements are met and a record is found, applicant is entitled to certified copies. A statement will be issued if no record is found. FEE MUST ACCOMPANY APPLICATION. [redacted] payable to: Polk County Health Center
State recording of birth and death records began January 1, 1910.

BIRTH NUMBER OF COPIES 1 (FIRST COPY ISSUED $15; EACH ADDITIONAL COPY $15)

FULL NAME ON CERTIFICATE [redacted]

ALSO KNOWN AS [redacted] (IF BIRTH COULD BE RECORDED UNDER ANOTHER NAME) 7

DATE OF BIRTH [redacted] PLACE OF BIRTH (CITY, COUNTY, STATE) [redacted]

HOSPITAL CMH SEX FEMALE ☐ MALE ☒ RACE [redacted]

FULL MAIDEN NAME OF MOTHER [redacted]

FULL NAME OF FATHER

DEATH NUMBER OF COPIES _____ (FIRST COPY ISSUED $13; EACH ADDITIONAL COPY OF THE SAME RECORD ORDERED AT THE SAME TIME $10)

FULL NAME ON CERTIFICATE _____

DATE OF DEATH _____ SEX FEMALE ☐ MALE ☐ RACE _____

PLACE OF DEATH (CITY, COUNTY, STATE) _____

FULL NAME OF SPOUSE _____

FULL NAME OF FATHER _____

FULL MAIDEN NAME OF MOTHER _____

PLEASE ENCLOSE A SELF-ADDRESSED STAMPED ENVELOPE WITH YOUR REQUEST (PRINT THE FOLLOWING INFORMATION)

APPLICANT'S NAME [redacted] PHONE NUMBER [redacted]

APPLICANT'S STREET ADDRESS [redacted]

APPLICANT'S CITY/TOWN

PURPOSE FOR CERTIFICATE REQUEST personal records

YOUR RELATIONSHIP TO PERSON NAMED ON RECORD (IF LEGAL GUARDIAN, MUST PROVIDE GUARDIANSHIP PAPERS). IF LEGAL REPRESENTATIVE, INDICATE LEGAL RELATIONSHIP. Mother

➢ MAIL-IN REQUESTS MUST BE NOTARIZED. ALL APPLICATIONS MUST BE SIGNED.

I _____ DO SOLEMNLY DECLARE AND AFFIRM THAT I AM ELIGIBLE TO RECEIVE A CERTIFIED COPY OF THE VITAL RECORD(S) REQUESTED ABOVE AND THAT THE INFORMATION IS TRUE UNDER THE PAINS AND PENALTIES OF PERJURY.

➢ APPLICANT'S SIGNATURE [redacted] DATE _____

	SUBSCRIBED, DECLARED AND AFFIRMED BEFORE ME, THIS _____ DAY OF _____, 20 ____	USE RUBBER STAMP IN CLEAR AREA BELOW
	NOTARY PUBLIC SIGNATURE / MY COMMISSION EXPIRES	
	NOTARY PUBLIC NAME (TYPED OR PRINTED)	

Date:_____ Cert#:_____ ID:_____ Payment:_____

Personal check or money order should be made payable

[redacted]

New York

(except New York City)

Event: Birth

Cost of copy: $30.00

Address:
Certification Unit
Vital Records Section
2nd Floor
800 North Pearl Street
Menands, NY 12204

1(855) 322-1022.

http://www.health.state.ny.us.

Personal check or money order should be made payable to New York State Department of Health. Payment of mail order copies submitted from foreign countries must be made by a check drawn on a United States bank or by an international money order.